‘Together in Work, but Alone at Heart’: Insider Perspectives on the Mental Health of British Police Officers

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Introduction

In recent years, there has been a burgeoning interest in the complex interface between mental health and policing. The diversity of research in this area is reflected in a cursory glance at the recent evidence base, which includes analysis of: mental health street triage (Dyer, Steer and Biddle 2015); police responses to mentally disordered homeless populations (Normore, Ellis and Bone 2015); and police officers' use of restraint in mental health settings (Haidrani 2017). However, the issue of mental health problems *amongst police officers themselves* continues to receive limited consideration. Given the demanding pressures of contemporary policing (Joyce 2011), it is surprising that this area continues to attract such little attention. In the United Kingdom (UK), three notable studies have revealed statistically high rates of mental health problems amongst British police officers. In a robust large-scale study conducted by the Police Federation, approximately 17,000 police officers from England and Wales completed an online survey concerning work demands and welfare. Results showed that 80% of respondents reported high levels of stress and poor psychological well-being, with cause attributed to a range of organisational, occupational and psychosocial factors (Houdmont and Elliot-Davies 2016a, 2016b). Research by the mental health charity, Mind (2015), found a remarkable 90% of participating police officers reported poor mental health whilst on duty. These concerning findings were corroborated in a study by police charity 'Call4BackUp' (2015), where a third of the 525 police officers taking part disclosed a clinically diagnosed mental disorder, and a fifth reported suicidal ideation. These studies indicate that levels of mental illness within the police are considerably higher than the general population. Furthermore, it is of concern that officers invariably felt unsupported by senior management and the organisation as a whole.

Such statistical analysis has been invaluable in highlighting the extent of mental health problems amongst officers. However, it is essential that research moves beyond such patterning exercises to understand causal factors from the perspective of police officers themselves: the problem needs to be contextualised from the inside and from the ground up. The current research therefore aimed to explore the attitudes, opinions and perceptions of current police officers in regard to mental disorder within the service. Opinions about the efficacy of current support mechanisms were also sought.

Methods

This study was underpinned by an interpretivist approach that aimed to generate insights into the attitudes, opinions and experiences of police officers in relation to mental illness amongst colleagues (Ormston et al. 2014). With the assistance of a senior police officer acting as gatekeeper, we were able to interview six serving police officers. The sample was established from a scoping email sent by the gatekeeper, to each police department. This email outlined the aims of the research and asked for volunteer participants; it was stipulated that personal experience of mental illness was *not* necessary. A total of thirty-five officers responded to the email, with six selected for interview. These included three males and three females, with an age range of 30-55 years. *Table 1* outlines key information about the sample; including rank, department and length of service.

Table 1: Sample Group (Descending by Rank)

Name	Sex	Service Length	Rank and Department	Interview Length
FCI	Female	23 years	Chief Inspector (Response)	7442 words
MI	Male	18 years	Inspector (Neighbourhood)	8146 words
FDS	Female	22 years	Detective Sergeant (CID)	7228 words
MS	Male	28 years	Sergeant (Neighbourhood)	10031 words
FD	Female	16 years	Detective (Violence)	9871 words
MPCSO	Male	10 years	Police Community Support Officer (PCSO) (Neighbourhood)	8785 words

A series of semi-structured interviews was conducted in January 2017. A pre-determined set of open questions provided consistency, but participants were free to explore issues relating to their perceptions in greater detail (Irvine et al. 2013). Individuals were not asked to discuss their own personal experiences of mental illness, although several took the opportunity to do so. All interviews were audio recorded and transcribed verbatim, producing a total of 51,000 words. Data was anonymised and displaced in the transcription process. The mean length of interviews was 82 minutes. Data was subsequently analysed using interpretative phenomenological analysis (IPA). This involved a cyclical process in which the participant makes sense of their experiences, while the researcher simultaneously interprets meaning (Smith et al. 2009). This required multiple readings of interview transcripts to identify recurrent themes across participant narratives.

Findings and Discussion

Findings are organised around the following three headings: *prevalence of mental health issues amongst police officers*; *causes of mental health issues amongst police officers*; and *mental health support for police officers*.

Prevalence of Mental Health Issues amongst Police Officers

Our findings suggest that mental health issues are pervasive amongst police officers. One senior officer felt strongly that mental illness in the police was 'endemic', stating, 'it seems now, so much more than when I joined, that more people are suffering with proper, real stress and depression' (FDS). All six participants believed that their organisation had a 'serious problem' (MI) related to mental health related sickness, and some believed that the aforementioned statistics produced by *Mind* (2015) underrepresented the extent of the problem. The participants drawn from higher ranks provided

numerous examples of staff under their management who had suffered with mental illness. When asked for a recent example, one senior officer remarked, 'God, there's loads in this organisation – how long do you have?! I can confidently say, that 100% of police officers have at some point experienced poor mental health' (MI). A variety of mental health issues were highlighted within participant narratives, including: stress, postpartum depression, addiction, bi-polar affective disorder, anxiety, and depression.

In addition to making reference to the wider problem of mental illness amongst police officers, several participants provided detailed personal accounts of their own experiences of psychological distress. As the interview schedule had not sought such data, this finding was somewhat unexpected and demonstrated the pervasive, yet hidden, nature of this problem. Three of the officers interviewed had received a formal mental health diagnosis within the previous five years. Diagnoses included stress, depression, post-traumatic stress disorder (PTSD), and anxiety disorder. The officers concerned had taken a combined total of 48-weeks of sick leave between them; whilst all had now returned to work, several continued to take prescribed anti-depressant medication. One participant disclosed that at one point, he had been so concerned about his mental health, that he had feared being detained under the Mental Health Act: 'I seriously thought I would end up in a psychiatric hospital. I thought "I'm going mad and I'm going to end up sectioned … I'm never coming back' (MS). This demonstrated the serious extent to which his depression had reached before he felt able to take sick leave.

The issue of 'presenteeism', defined as presenting for work when unfit to do so (Pohling et al. 2016), frequently arose within interviews. Research by the Police Federation (2016) has claimed that this is a consequence of officers feeling pressured to attend work to cover service gaps caused by financial cuts to police budgets. However, our participants offered an alternative perspective. Senior officers expressed a belief that junior colleagues with mental health issues avoided sick leave, not from a sense

of altruistic duty, but because the stigma associated with such disorders was a major barrier to career progression. This view was outlined by a senior participant, who suggested that the formal recording of mental illness on sickness records would seriously inhibit chances of gaining internal promotions or moving to other forces.

> If you apply for a job and your sickness record shows that you've had mental health problems, the perception is that they don't want people like that. They don't want people who are going to bring problems to the department or the table. I don't think you would get very far. Lawfully they can't prevent you, but I'm sure they'd find a reason why (FDS)

Furthermore, this perceived need for officers to hide psychological problems was seen as particularly relevant within the 'coveted' firearms department, where, quite simply, 'mental illness is not allowed' (MI)*:*

> There is massive presenteeism because you could never go sick with stress on Firearms, they'd take your firearms licence off you. You get unlimited overtime so it's a massively lucrative job … but the presenteeism is huge, and really dangerous. Those staff will never present to you with anything psychological (MI)

Although the impact of financial cuts was mentioned by all participants, the conclusions drawn about presenteeism by the Police Federation (2016) were absent in their narratives, suggesting that further research is required to better understand the issue. In summary, mental illness amongst police officers was regarded as endemic; the current research therefore corroborates the findings of previous research by Mind (2015) and Call4BackUp (2015).

Perceived Causes of Mental Health Issues amongst Police Officers

Organisational Bureaucracy and Psychological Harm

The trauma of repeated exposure to critical incidents is well established to be a causal factor of psychological distress in emergency workers and military personnel (Weltman 2010; Williams 2013; Verey and Smith 2012). There has been considerable academic focus on the causes of stress amongst

police officers, with interpersonal, organisational and occupational issues all identified as key causal factors (Abdollahi 2013: 17). Whilst exposure to traumatic critical incidents is often cited as the principal source of psychological distress (Houdmont, Kerr and Randall 2012), other researchers have prioritised the detrimental impact of organisational culture and unmanageable workload as key issues in officer stress (Collins and Gibbs 2003). For example, in a recent survey of Scottish police officers, almost half of the 17,000 respondents cited 'the possibility of being the subject of a complaints investigation' as a key source of occupational stress (Falconer, Alexander and Klein 2013: 9). Interview data for the current research showed that all six participants overwhelmingly perceived organisational 'bureaucracy' to be the biggest source of poor psychological wellbeing amongst police officers, as one participant commented: 'More of the stress in this job comes from within the police station, than it does from outside the police station' (MS). The 'excessively complicated procedures' (MS) of the police organisation was consistently attributed as a principal cause of mental illness amongst officers. This theme was found in all interviews, including higher ranking officers:

> It's honestly the internal bureaucracy that makes life really hard. If I put a request in to the force resources… I know it's futile. But I do it. Because then I can go to the meetings and say, "I did it". (MI)

These perceptions were consistent with Clarke's (1998) study on the impact of managerialism culture on social welfare institutions. The researcher's theory of 'doing things right' versus 'doing the right thing' appeared repeatedly in participant narratives of the current study, with stress rooted in having to 'cross the T's and dot the I's' ('doing things right') at the expense of 'common sense and human interaction' ('doing the right thing') (MS). One participant highlighted how the pressure of trying to meet the 'unrealistic expectations' of the organisation had caused a colleague to experience suicidal ideation:

> But the job [organisation] is so scared, they pushed this poor lad to the point where he wanted to kill himself, but they don't care about that, they're more focused on getting the paperwork done (MS)

In reflecting further on organisational demands, participants detailed the way in which a 'Big Brother culture' had produced a 'constantly paranoid' police force (MI). As one participant stated, 'after the MacPherson Report, officers started pointing fingers at each other. All the time you're trying to work it out… what can I say? What can't I say?' (MS). The impact of national police controversies seemed to feature heavily in officer narratives, in which they were convinced they were 'continuously being watched' (MI); the shadow of the Hillsborough inquiry loomed large in this respect:

> Thirty years after Hillsborough and somebody is still going through it all with a fine toothcomb, and that's what worries people. In a few years' time, people will look at something and say, "you didn't deal with this properly" (MS)

Participants therefore felt that the toll of balancing the conflicting demands of an 'anxious organisation' (MI) was a key contributor of mental health issues amongst officers. One interviewee felt that senior officers' reluctance to support staff created feelings of professional isolation:

> Chief Constables say, "if you do something wrong, but have acted in the best interest of the public, we will support you" …but it just doesn't work like that (MS)

In this sense, several participants alluded to the psychological dissonance created in trying to do a 'very human job' (FD) within an organisation that increasingly felt like a 'private company' (FD).

Minimising Trauma in a Culture of Invincibility

Interviews revealed that whilst participants readily blamed 'the organisation' for poor mental illness amongst police officers, they were simultaneously reluctant to locate the cause of mental distress at the level of individual psychopathology. Police officers' reluctance to discuss psychological injury has been noted in recent research, and remains an issue that is under-researched (Bell and Eski 2016: 95). None of our participants independently identified the impact of trauma as a precipitating factor in mental illness amongst officers. This contradicts the evidence found amongst similar professions (see Williams 2013 and Verey and Smith 2012) and in research with police officers (Walsh, Taylor and

Hastings 2013). Interviewees were quick to deny the impact of exposure to critical incidents, and to some extent seemed to revel in the graphic descriptions of 'jobs' they had attended:

> You go to a sudden death, or a hanging and you just get on with it. I've lost count of how many bodies I've seen. You see them in various forms…bits of bodies…other horrific crimes. But you get used to it in the end…you expect what you get on the outside (MS)

This ambivalence to trauma, and dismissive denial of its impact on mental wellbeing, is in many ways similar to the attitudes found in military personnel (Verey and Smith 2012). This is exemplified in an interview excerpt from the PCSO participant:

> I had one body where I can still picture it now…it wasn't particularly bad or gruesome or anything, it just stays with you. But it doesn't bother me or upset me, I just think about it sometimes (MPCSO)

The irony of this statement is apparent to the 'outsider', in which the participant rationalises *'just'* picturing and ruminating about a dead body, assuring the interviewer of his psychological 'toughness'. It is of note, that none of the participants had access to any type of forum to reflect on critical incidents. Given that this is central to the role of paramedics and other health care professionals, in the form of clinical supervision (Williams 2013), this appears to be a glaring omission that leaves police officers to internalise the impact of involvement in traumatic events.

This explicit denial of the impact of trauma perhaps explained why 'The Organisation' was so readily blamed as the cause of mental health issues, with two participants admitting that their years spent working as police officers had made them 'numb' (MI and MPCSO). Interestingly, the officer who had described his fear of being sectioned, welcomed the possibility of a biological cause for his distress. This explanation simultaneously enabled him to deflect narratives of psychological fragility and obfuscated the potential impact of trauma exposure: 'I still can't see what caused it. They've said it could have just been a chemical imbalance. I'm happy with that' (MS).

In trying to unpack the deeper causes for this reluctance to acknowledge the impact of trauma, we found many participants alluded to a 'culture of invincibility', consistent with 'cop culture' research (Loftus 2009) and military 'self-stigmatisation' (Murphy 2014): 'After all of them [ambulance and fire service], it finally comes to us. There's no one else to save the day. So, we always need to be the superheroes, if you like.' (MI). Female participants felt that this was particularly true for male officers, who they felt were under pressure to '*man up*' (FDS) because of cultural 'bravado' (FDS). Nevertheless, this issue crossed gender boundaries; for example, a female participant who had previously been on sick leave with depression, noted: 'I never stop to think "actually, this is really hard and I'm just doing the best I can", and I suppose I should sometimes, shouldn't I?' (FD). This cultural 'machismo' (Myhill and Bradford 2013) also seemed to contribute to the lack of organisational response to mental illness, as the most senior ranked participants stated, 'we still have more than just the remnants of a macho culture as an organisation' (FDCI). These narratives had many similarities with the 'culture of toughness' found by Loftus (2009) and in studies of military personnel (see Verey and Smith 2012). Several participants lamented that sick leave related to physical injury / illness was more culturally acceptable than taking time off for psychological distress. Yet paradoxically, all interviewees talked disparagingly of colleagues who had 'pulled a fast one' (MI) and 'used' mental illness to obtain paid sick leave. Such contradiction and ambiguity permeated participant attitudes about mental illness. The complexity of the issue is borne out in narratives that primarily lay blame on the 'faceless' managerialism of the organisation, whilst simultaneously negating any real impact of trauma on individual mental health. Furthermore, it seems that when police officers *do* reveal signs of psychological distress, they risk the condemnation of their colleagues for 'taking the piss' (MPSCO). As one participant stated:

> I think people take advantage in this organisation. They go to our Occupational Health, tell them "I can only do four hours a day because I'm feeling stressed and anxious" and Occy Health say "fine, that's okay!", without actually probing it (FDS)

Mental Health Support for Police Officers

Participants in this study consistently made reference to a perceived lack of organisational support. This was a view extolled from both those with personal experience, and from managers who had tried in vain to access services on behalf of colleagues. One officer described Occupational Health as, *"a complete mess"* and offered a personal experience of unrequited support: "*When I went off last year they offered me an appointment. It's been 12 months now. I'm still waiting."* (MS). This was reflected in other narratives, with financial resources deemed a key issue: *"They can't do as much as we need them to. They used to be excellent, but then the funding was cut. We are all struggling"* (FDS). It was concerning that only one participant was aware of the existence and function of the 'Blue Light Programme'. This service is available to all emergency service personnel and their families, and provides a confidential support information line, as well as free mental health resources and awareness training in-force (Mind 2015). It is purported to be a considerable success (Mind 2016), however, the lack of awareness amongst our participants suggests organisational assumptions about the efficacy of this programme may be overestimated. Given the endemic nature of mental health issues amongst police officers, and associated stigma, it seems clear that the provision of effective support mechanisms is vital.

Whilst several participants were critical of the perceived inefficiency of the occupational health department, grassroots participants were also sceptical of the department's ability to maintain confidentiality. One officer laughed as she told us, 'there's no such thing as a secret in the police' (FD), whilst another stated: 'it's supposed to be confidential, and they say that they would support you, but I don't think that they would really. They wouldn't keep you, why would they?' (FDS). The male sergeant was similarly cynical in this respect, asserting, 'they just want to get you back in the job'. As a result of the mistrust of occupational health systems, participants argued that most police officers were unlikely to seek help from the organisation because of the 'massive stigma' surrounding mental

illness (MI). Several interviewees explained that although the organisation had an 'official line' on mental illness, the reality was quite different and that once a diagnosis of mental illness 'got out [your] card was marked' (FDS).

Interestingly, it was not only formal systems of support that were criticised within interviews. The opportunity to share anxieties with colleagues is a renowned protective factor amongst paramedics and military personnel (Streb et al. 2014; Verey and Smith 2012). However, many of our participants felt that the surveillance culture associated with managerialism had fractured the opportunity for 'down time' between police officers (MS). In this respect, several participants recognised the important role that police social clubs had played in the past. These informal spaces were a chance for officers to socialise and share concerns and anxieties about traumatic aspects of their role:

> We had bars in the stations, and that's how we dealt with it. If you'd been to a horrible job…maybe a child death or where you'd seen people mangled or dying, you could go up there, chat, have a drink, and then you didn't feel like you needed to talk about it when you got home. That was the best way of getting things off your chest before you left work (FDS)

The majority of these social spaces have, of course, been closed. As found by Loftus (2008: 764) participants in the current research identified the Macpherson Report (1999) as a negative driving force behind organisational change. Two participants directly attributed this to the loss of social space, as the report condemned informal 'backstage' conversations between officers and identified 'canteen culture' as the root of prejudicial attitudes (Waddington 1999). One interviewee acknowledged that "*police alcoholism"* had been associated with such social clubs, but argued that feelings of professional isolation were now so powerful that she even felt disconnected from colleagues during the day:

> We don't have canteens where you can go and sit and chat. You bring your own lunch. I eat at my desk. Everyone eats at their desk; we just get on with it. We're together in work, but alone at heart (FDS)

It seemed counterintuitive that, unlike the paramedic service, where the benefits of 'downtime' and strong interpersonal relations are acknowledged as paramount in maintaining emotional resilience (Williams 2013), the police organisation effectively promotes the opposite. This is an important factor as the sense of camaraderie that has traditionally bound police officers together has been identified as a core pillar of support in the past, particularly as many officers feel socially isolated from 'civilian' friends and family (Loftus 2009, 2010). For almost twenty years, 'canteen culture' has been condemned as a source of organisational discrimination (Charman 2015), but for the participants in this study, attempts to eradicate these issues seems to have simultaneously destroyed vital informal support mechanisms.

Conclusion

Researching the police is notoriously problematic due the closed nature of the organisation. As one of participant astutely observed, much of police culture is hidden behind a 'brick wall. You can remove one brick, but you won't get to see much more' (FDS). Our aim here has been to offer a glimpse behind this brick wall, to generate understanding about the important issue of police officers' mental health, from the perspective of those on the inside.

The narratives revealed themes that were unexpected, and in some ways controversial. Clearly, it would seem that research by Mind (2015) and Call4BackUp (2015) is accurate in highlighting significant rates of mental illness amongst police officers. Although participants were reluctant to acknowledge the impact of trauma, they strongly believed that psychological distress amongst police officers was a serious and pervasive issue. Participants attributed this to the stress induced from working within the parameters of the bureaucratic organisation, and minimised the impact of traumatic work events. In reality, it is likely that *both* of these issues are detrimental to psychological well-being, and this is further exacerbated by a police culture that discourages officers from revealing any signs of

fragility. In this respect, it would seem essential to consider educational campaigns that chip away at stigma and the perceived need to maintain a façade of invincibility.

In regard to support, financial restraints seem to have curbed the efficacy of Occupational Health provision, leaving participants unable to access services when needed. Furthermore, the general distrust of Occupational Health led all participants to assert the need for independent formal support structures *outside* of the police organisation. They wanted a provision that offered access to 'clinical professionals' (FCI) and which afforded them unconditional confidentiality. It is also important to note that there are examples of innovative police practice in relation to trauma exposure, and these interventions should be urgently considered for national implementation. For example, several UK studies have demonstrated that the employment of the *Trauma Risk Management* (TRiM) approach can reduce sickness absence and ameliorate the effects of trauma in both police officers (Hunt et al 2013; Walsh, Taylor and Hastings 2013) and military personnel (Greenberg et al 2010). The absence of effective, consistent access to formal support made the loss of social space all the more important. This seems to have created a palpable sense of professional isolation by destroying essential informal support networks. This suggests that the provision of shared social spaces should genuinely be reconsidered, particularly as the more negative aspects of 'canteen culture' may now have been dissipated by wider cultural shifts within the police service, as one senior officer intimated: 'When I went to [names police force] in the early 2000s, I went to a sexist, racist, archaic organisation … but now, it's probably one of the most forward thinking and modernist organisations' (MI). However, it is important to note that such cultural shifts may have occurred on a superficial level, masking the entrenched values, practices and attitudes of the past (Loftus 2008: 763 and Loftus 2010: 16).

This study demonstrates the importance of undertaking qualitative research in constructing nuanced understandings of mental illness amongst police officers. While quantitative studies may be quick and cost efficient, the complexities of mental illness amongst police necessitates an approach which is capable of appreciating the "rush of emotions and feelings which characterise the human condition"

(Young 2011: 225). The findings here demonstrate the need for a cultural shift at both an organisational and individual level. Many police officers are required to deal with extraordinarily traumatic incidents, it is time that the psychological impact of this is given the attention and resources that it deserves.

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